TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOPAEDIC & SPORTS MEDICINE CLINIC

MFDR Tracking Number
M4-17-2277-01

MFDR Date Received
March 28, 2017

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider the attached claim for the brace given on date of service 12/12/16 as it was medically necessary for the patient to receive a different brace based on his diagnosis that was later identified by his MRI."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed $650.00 for a brace, code L1833. Texas Mutual paid $0.00 because Rule 134.600(p) (9) states all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental) requires preauthorization. Texas Mutual reviewed its claim file and found no request for preauthorization of the DME nor has the requestor provided any evidence in the DWC60 that it sought preauthorization."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
December 12, 2016	L1833	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-197 – Precertification/authorization/notification absent
   - 930 – Pre-authorization required. Reimbursement denied
   - 891 – No additional payment after reconsideration

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS Code L1833, DME rendered on December 12, 2016. The insurance carrier denied the disputed charge with denial reason codes "CAC-197 – Precertification/authorization/notification absent" and "930 – Pre-authorization required. Reimbursement denied."

   28 Texas Administrative Code §134.600(p) (12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)."

   Review of the submitted documentation supports that the requestor billed $650.00 for HCPCS Code L1833, this is in excess of $500.00, per 28 Texas Administrative Code §134.600(p) (12) the disputed service required preauthorization. The requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed service. The Division finds that the disputed service required preauthorization prior to dispensing the DME to the injured employee.

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The Division finds that the requestor did not obtain preauthorization for the disputed service, as a result, the insurance carrier is not liable for payment for this disputed charge.

2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for disputed HCPCS Code L1833 rendered on December 12, 2016. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 20, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.